D 16
<u> </u>
(X5)
COMPLETION
DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000150

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155246 B. WING 05/31/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 110 BEVERLY DR CHESTERTON MANOR CHESTERTON. IN 46304 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG SS=D **PROHIBIT** Bldg. 00 MISTREATMENT/NEGLECT/MISAPPROP **RIATN** The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. F 0224 F224 483.13 Prohibit 06/30/2016 Based on record review and interview, Mistreatment/Neglect/Misappro the facility failed to ensure each resident priation: was free from misappropriation of It is the practice of Chesterton property related to drug diversion for 3 of Manor to ensure residents are not 3 residents reviewed for abuse. subjected to misappropriation of (Residents #5, #37, &, #101) 1.Resident #5, #37, & #101 has the potential to be affected by this Finding includes: alleged deficiency. 2.All Residents orders related to The abuse allegation of misappropriation controlled substances have been of property provided by the Director of reviewed and compared with Nursing was reviewed on 5/26/16 at controlled substances available. This was a 100% Audit to determine and 10:45 a.m. identify if any other residents were affected with no other deficient The allegation of medication diversion practice identified. was dated 4/22/16. The DON reported a 3.All licensed nurses have been discrepancy of controlled substance re-educated on this policy June 16, found on 4/21/16. On 4/21/16 at 11:15 2016. All controlled substance orders have been reviewed. In p.m., LPN #4, the night shift nurse, addition to the review and texted the DON and notified her when re-education, the DON, or her she and the second shift nurse RN #3 designee, is conducting a quality counted the 300 hall medication cart improvement audit to ensure all narcotics someone had taken 2 dose residents continue to be free of packs and punched out the Hydrocodone Misappropriation of Property. All Resident controlled substances will replacing them with a look a like and be monitored weekly for 30 days, taped the back. LPN #4 indicated to the then monthly for 6 months. Results DON the last time she had worked the of these audits will be reported

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		155246	B. W	ING		05/31/	2016
NAME OF I	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP CODE		
					VERLY DR		
CHESTE	RTON MANOR			CHEST	ERTON, IN 46304		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ampered with which was			monthly to the Quality Assurance meeting. Any negative findings will		
	4/19/16.			add another four weeks of audits			
					until 100% compliance is achieved.		
		nursing schedule was			4.Date of Completion: June 30,		
	-	narcotic count sheet and			2016.		
	all the nurses we	ere interviewed.					
	The controlled substances involved were						
	Resident #5's routine Hydrocodone 3/325						
	mg was diverted and replaced with						
	Hydroxychloroquine. Resident #101's						
	routine Hydrocodone 7.5/325 mg was						
	diverted and replaced with						
	Hydroxychloroq	uine. Resident #37's					
	Hydroxychoroqu	aine was diverted from					
	her packaged an	d replaced in above.					
	The record for R	tesident #5 was reviewed					
	on 5/24/16 at 2:2	20 p.m. The resident's					
	diagnoses includ	led, but were not limited					
	to, planned post	procedural wound					
	closure, pain left	t wrist, spinal stenosis,					
		e, high blood pressure,					
	_	orbid obesity, and					
	epilepsy.	3 /					
	The Annual 3/16	6/16 Minimum Data Set					
		ent indicated the resident					
		view for Mental Status					
		15 indicating she was					
	` ′	•					
	alert and oriented. The resident received scheduled pain medication, and						
	•	I pain in the last 5 days.					
	_	icated in the interview					
	THE TESIGETIC IIIG	icated iii tiie iiitelview					

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-	OF CORRECTION	IDENTIFICATION NUMBER: 155246	A. BUILDING 00 B. WING			COMPL 05/31/	ETED
	PROVIDER OR SUPPLIER			110 BE\	DDRESS, CITY, STATE, ZIP CODE VERLY DR ERTON, IN 46304		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) V score was 3 out of 10.	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	The current 3/27 indicated the resirelated to periphe stenosis, and the osteoarthritis. The were to administ medication) as properties of the summary, with a indicated Hydrod medication of the times at the record for R reviewed on 5/24 resident's diagnor limited to, diabeted immune hepatitis pain, pubic fractuliver inflammator osteoarthritis. The Minimum D assessment dated resident had a Br Status (BIMS) of alert and oriented scheduled pain in frequently had particular to the properties of the status (BIMS) of alert and oriented scheduled pain in frequently had particular to the properties of the status (BIMS) of alert and oriented scheduled pain in frequently had particular to the properties of the status (BIMS) of alert and oriented scheduled pain in frequently had particular to the properties of the status (BIMS) of alert and oriented scheduled pain in frequently had particular to the status (BIMS) of alert and oriented scheduled pain in frequently had particular to the status (BIMS) of alert and oriented scheduled pain in frequently had particular to the status (BIMS) of alert and oriented scheduled pain in frequently had particular to the status (BIMS) of alert and oriented scheduled pain in frequently had particular to the status (BIMS) of th	ident had chronic pain eral neuropathy, spinal diagnosis of the Nursing approaches er analgesia (pain rescribed. It is on the 4/2016 in original date of 9/9/15, codone (a narcotic pain filligrams (mg)/325 mg 1 day. It is included, but were the mellitus, auto is, diverticulosis, chronic cure, high blood pressure, rry disease, and It is indicated the fief Interview for Mental of 13 indicating, she was did. The resident received medication, and min. The resident ast 10 days her pain					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155246		ľ í	JILDING	NSTRUCTION 00	(X3) DATE COMPL 05/31 /	ETED	
	PROVIDER OR SUPPLIER		•	110 BE\	DDRESS, CITY, STATE, ZIP CODE /ERLY DR ERTON, IN 46304	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	3 RIATE	(X5) COMPLETION DATE
	the resident had back right should	16 plan of care indicated pain related to lower der and leg weakness. broaches were to provide as ordered.					
	Hydroxychloroq to treat the inflar arthritis) 200 mi a day. The resid	res on the 4/2016 red the resident received uine (a medication used mmation of rheumatoid lligrams (mg) 1 tab twice ent also received 5-325 mg 1 tab every 6					
	reviewed on 5/2: resident's diagno not limited to, he pressure, demen- depression, perip rheumatoid arthr	esident #101 was 5/16 at 8:43 a.m. The ses included, but were earing loss, high blood tia with behaviors, oheral vascular disease, ritis, diabetes, diabetic back pain, and pain					
	(MDS) assessme indicated the res for Mental Statu indicating she w and severely imp making. The res	Minimum Data Set ent dated 3/15/16 ident had Brief Interview is (BIMS) score of 3, as not alert and oriented paired for decision dident was not able to be beain, however, there were					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155246	l í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 05/31/	ETED
	PROVIDER OR SUPPLIER	2		110 BE\	.ddress, city, state, zip code /ERLY DR ERTON, IN 46304		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	no physical sign: pain.	s the resident was in					
	_	ers on the 4/2016 ted the resident received 5 mg/325 mg 1 tab twice					
	to one particular rehired in 7/2013 narcotics were reclock in and out inconsistent. LP	nurse LPN #1, who was 5. The paperwork for eviewed and compared to times and found to be PN #1 was assigned the rt on 4/21 and 4/22 for					
	Administrator continued interview with Land Consultant intervalsed her about and after her shift narcotic resident the nurse had significant the nurse had significant that no responsible allegations. LPN took the narcotic family member won the following week.	N #1 finally admitted she es and gave them to a who was having surgery Wednesday of that					
l	LPN #1 was imr	nediately suspended and					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155246	ľ í	UILDING	NSTRUCTION 00	(X3) DATE COMPL 05/31/	ETED
	PROVIDER OR SUPPLIER			110 BE\	DDRESS, CITY, STATE, ZIP CODE /ERLY DR ERTON, IN 46304		
CHESTE (X4) ID PREFIX TAG	Interview with the Administrate two residents to who was having future. The DOI admitted she had medication of H another resident. Interview with the Interview with the Administrate the Administrate the Administrate the Administrate the Administrate the Administrate the Interview with the Administrate the Interview with the Interview	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) on 4/26/16. The DON on 5/25/16 at cated LPN #1 admitted otics during the second are Nurse Consultant and or. The DON indicated and Hydrocodone from the give to a family member surgery in the near N indicated the nurse also at taken the look alike hydroxychloroquine from the replace the stolen The Nurse Consultant on a.m., indicated she was				ATE	(X5) COMPLETION DATE
	present during L she did admit to for a family men The current 8/24 policy provided at 9:45 a.m., ind of Resident Prop misplacement, e- temporary or per	PN #1's interview and stealing the medication ober. /15 Reportable Incidents by the DON on 5/27/16 icated "Misappropriation berty was deliberate exploitation, or wrongful, rmanent use of a rty of money without the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		155246	B. WI	NG		05/31/	2016
	PROVIDER OR SUPPLIEF		•	110 BE	ADDRESS, CITY, STATE, ZIP CODE VERLY DR ERTON, IN 46304		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F 0282 SS=D Bldg. 00	CARE PLAN The services prove facility must be propersons in accord written plan of car Based on observe interview, the faresident's plan or related to trached the windpipe may obstruction to be suctioning for 1 for tracheostomy who met the criticare. (Resident #Finding includes On 5/24/16 at 2: was observed in tracheostomy (tracheostomy (tracheostomy (tracheostomy daily to were not suction manner. The record for Resident #Finding daily to the suction manner.	ation, record review, and cility failed to ensure a f care was followed ostomy (an incision in ide to relieve an reathing) care and of 1 resident reviewed v care of the 1 resident eria for tracheostomy \$\frac{4}{35}\$) 55 56 p.m., Resident #35 bed. The resident had a ach) observed with an air ystem attached. The d at the time he was not rach care and the staff ing him in a timely	F 02	282	F282 483.20 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of car It is the practice of Chesterton Manor to ensure aresident's plof care is followed related to tracheostomy care and suctioningfor residents who methe criteria for tracheostomy car. I. One Resident, Resident # 38 has a tracheostomy care was being completed but not being documented on in the treatme administration record. II. One Residents who has a tracheostomy has the potential be affected by this alleged deficiency. III. As noted in the survey findings, Chesterton Manor has a Tracheostomy Capolicy. A clarification order for Resident #35 has been received All plans of care for Resident # have been reviewed for compliance. No other deficient practice identified. Licensed	et are. 5, nt I to are ed. #35	06/30/2016

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155246	` ′	JILDING	onstruction 00	(X3) DATE COMPL 05/31/	ETED
CHESTE	PROVIDER OR SUPPLIER		•	110 BE' CHEST	ADDRESS, CITY, STATE, ZIP CODE VERLY DR ERTON, IN 46304	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	to, quadriplegia, and chronic resp The Significant of Set (MDS) assess indicated the result indicated the result indicated. The extensive assist two people for the and lower extrems ides. The specific but were not limited suctioning. The current and indicated, the restracheostomy relimiter ventions incomplimited to, suctions in the shift as ordered as the series of the 5% indicated, may some increased secretion of the 5% Administration In documention.	Change Minimum Data sement dated 4/5/16 ident had a Brief ental Status (BIMS) score the resident was alert he resident was an with a physical assist of ransfers and had upper nity impairments on both all treatments included, ited to, trach care and updated care plan sident had a lated to an injury. The cluded, but were not on and trach care every and prn (as needed). (2016 Physician's Orders function as needed for ons. There were no trach care.			nurses have been re-educate the aforementioned policy emphasizing the nursing tear record tracheostomy care in treatment administration record on June 13, 2016. IV. All Residents orders related to tracheostomy care have been reviewed. In addition to the reand re-education noted above the DON, or her designee, is conducting a quality improver audit to ensure all residents of plans are reviewed with each comprehensive assessmental followed as well as review of care plan related to tracheost care and suctioning for reside who met the criteria for tracheostomy care. All reside receiving tracheostomy care all resident care plans with each comprehensive assessment to be monitored weekly for 30 d then monthly for 6 months. Results of these audits will be reported monthly to the Quality Assurance meeting. Any negative findings will add and four weeks of audits until 100 compliance is achieved. V. D of Completion: June 30, 2016	n will he rd wi	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155246	l í	JILDING	NSTRUCTION 00	(X3) DATE COMPI 05/31	ETED
	PROVIDER OR SUPPLIER			110 BE\	DDRESS, CITY, STATE, ZIP CODE VERLY DR ERTON, IN 46304		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	days she provide which included a She further indicated the start the TAR when to "It's our facility provided daily an indicated the number of the cupolicy on 5/25/1 "Tracheostomy of maintain an airw	16 p.m., staff interview of Nursing (DON) If do not document on each care is completed, policy and is done daily." If we indicated she had no endicating trach care was end, moving forward, esing staff will be signing					
F 0309 SS=D Bldg. 00							

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155246 B. WING 05/31/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 110 BEVERLY DR CHESTERTON MANOR CHESTERTON. IN 46304 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of F 0309 F309 483.25 Qualityof Care 06/30/2016 Based on observation, record review, and Each resident must receive and interview, the facility failed to ensure the facility must provide the non-pressure areas related to bruises were necessary care and services to assessed, documented and monitored for attain or maintain the highest 1 of 3 residents reviewed for practicable physical, mental, and psychosocial well-being, in non-pressure related skin conditions of accordance with the the 4 residents who met the criteria for comprehensive assessment non-pressure related skin conditions. and plan of care. It is the (Resident #96) practice of Chesterton Manor to ensurenon-pressure related Finding includes: skin conditions are assessed, documented and monitored. 1.One Resident, Resident #96. On 5/23/16 at 10:22 a.m., Resident #96 was observed 5/23/16 with was observed with red/purple red/purple discolorations noted to discolorations noted to her right hand and her right hand and her left hand ringfinger without supportive her left hand ring finger. documentation until 5/26/16. 2.All Residents have the On 5/26/16 at 1:34 p.m., the Assistant potential to be affected by this Director of Nursing (ADON) was alleged deficiency. All residents assessed without findings. No observed performing a skin assessment other residents were effected. for the resident. At that time, she 3.As noted in the survey indicated the resident had three bruises. findings, Chesterton Manor has She assessed and measured each one as an Accidents and Incidents-Assessing, followed: Left 4th finger bruise 1 Investigating, and centimeter (cm) by 1 cm. The top of the Reportingpolicy. Licensed nurses right hand 1 cm by 0.5 cm and the right have been re-educated on the

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thumb 0.4 cm by 0.5 cm.

The record for Resident #96 was

reviewed on 5/26/16 at 10:00 a.m. The

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afore mentioned policy on

4.All Residents related to

non-pressure skin conditions

have been reviewed. In addition

June13, 2016.

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· ·		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING OO COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI B. WING	NG	00		
		155246				05/31/	2016
	PROVIDER OR SUPPLIE	R	11	0 BE\	DDRESS, CITY, STATE, ZIP CODE /ERLY DR ERTON, IN 46304		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREI TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	not limited to, a pacemaker, can pressure, conges history of falls. The Quarterly Massessment date resident had a B Status (BIMS) s she was not aler resident had no problems. She with one person transfers, bed matoilet use. The current 5/13 indicated the resproblems for corelated to Aspiria approaches were monitor/docume bruising. Observencounter for new 4/1/16 indicated on the left anticular discoloration, left purple discoloration for earm light purple discoloration.	dinimum Data Set (MDS) d 3/2/16 indicated the crief Interview for Mental core of 6 which indicated the desire and a sister and oriented. The behaviors, or mood was an extensive assist physical assist for obility, dressing and sident had potential implications for injury in therapy. The Nursing is to ent/report to the nurse we skin with each ew bruising or skin tears. The sessure wound sheet dated the resident had bruises ubital space dark purple off back of hand dark tion, and the right imple discoloration. There on-pressure wound			to the review and re-education noted above, theDON, or her designee, is conducting a qual improvement audit to ensurenon-pressure areas are assessed, documented and monitored. All residents willbe included in the audit related to non-pressure skin conditions, addition to the weekly skin assessments, and be monitor weekly for 30 days, then month for 6 months. Results of these audits will be reported monthly the Quality Assurance meeting Any negative findings will add another four weeks of audits u 100% compliance is achieved. 5.Date of Completion: June 3 2016.	in ed hly e to J.	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155246	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	CON	TE SURVEY MPLETED 31/2016
	PROVIDER OR SUPPLIEF	2	110 BI	ADDRESS, CITY, STATE, ZIP CO EVERLY DR TERTON, IN 46304	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	indicated there v	s Notes dated 5/22-5/26 was no documentation of her hands or fingers.				
		skin assessment sheet dicated the resident had skin integrity.				
	summary indicat	ers on the current 5/2016 ted the resident received grams (mg) daily.				
	1:34 p.m., indica just been implen assess bruises. S report was to be	the ADON on 5/26/16 at a new system had mented to monitor and She indicated an incident completed and the areas ared and documented on e sheets.				
	p.m., indicated s bruises on the re She further indic passed on to her	RN #1 on 5/26/16 at 2:00 he was unaware of the sident's hand and finger. eated no information was from the midnight shift ift report regarding the				
	Incidents-Assess Reporting policy Assistant Director	oll Accidents and sing, Investigating, and provided by the or of Nursing on 5/26/16 icated the licensed nurse				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU. B. WI		00		
		155246	B. WII	_		05/31/	2016
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CHESTE	RTON MANOR				VERLY DR ERTON, IN 46304		
(X4) ID				ID I			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL]	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
F 0323 SS=D Bldg. 00	will complete an resident involved. Documentation of include redness, of motion, pain, condition. 3.1-37(a) 483.25(h) FREE OF ACCIDE HAZARDS/SUPET The facility must environment remain hazards as is possible receives adequate assistance devices. Based on observational facility failed to trails were secure	assessment of the d in any incident. of that assessment may swelling, bruising, range bleeding, and change in bleeding, and change in bleeding as free of accident ins as free of accident sible; and each resident expervision and interview, the ensure the resident's side while in the upright d observed with side	F 03		F 323 SS=D 483.25(h) FREE CACCIDENT HAZARDS/SUPERVISION/DE' CESThe facility must ensure that the resident environment remains as free of accident hazards as is possible; and	DF VI	DATE 06/30/2016
	Finding includes	:			each resident receives adequate supervision and		
	1. On 5/24/16 at	9:23 a.m., 2:40 p.m.,			assistance devices to preven accidents. Finding includes:		
	•	e left side rail in room			1. The left side rail identified	in	
		ved in the upright			room 401-A has been repaire	d	
	-	se times, the side rail was			and restored to normal functionality, a 100 % audit h	as	
	loose and wobble	ed back and forth.			been completed to determine		
	2. On 5/25/16 at	9:23 a.m., and 12:57			any other resident side rails a		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			· ′	LE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN O	F CORRECTION				
		155246	B. WING		05/31/2016
NAME OF PR CHESTER (X4) ID PREFIX TAG	ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER RETON MANOR SUMMARY S (EACH DEFICIEN REGULATORY OR p.m., the left sid observed in the those times, the those times, the wobbled back ar Interview with the Supervisor on 5/ indicated he was loose. He further	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) e rail in room 401-A was apright position. At side rail was loose and and forth.	A. BUILDIN B. WING STRI 110	EET ADDRESS, CITY, STATE, ZIP CODE BEVERLY DR ESTERTON, IN 46304 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) loose or wobbly or in need repairs. All side rail determit to be affected have been an restored to normal functionality. a) An audit to has been created in the TEL electronic work order syste for weekly audits by maintenance as a task for weekly rounding and auditing This will be completed weel as a task for100 % audits of bed rails. In addition to weel rounds, a random audit of three resident bed rails will conducted weekly x 6 mont	COMPLETED 05/31/2016 (X5) COMPLETION DATE of ned d ol.s. m
SS=D Bldg. 00	from unnecessary drug is any drug w dose (including du			conducted weekly x 6 mont If the deficient practice is discovered and addition mowill be added to task and a record will be kept in the TE work order system. Results TELs audits will be printed weekly and kept in the POC binder as well as reporting finding in Monthly QA meetings. Staff has been in service on side rails and resident safety and reportin side rail issues in the TELs electronic work order syste with a completion date of 6/17/2016.	onth ELs of off the

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155246	l í	JILDING	onstruction 00	(X3) DATE COMPI 05/31	ETED
	PROVIDER OR SUPPLIEF	2		110 BE	ADDRESS, CITY, STATE, ZIP CODE VERLY DR ERTON, IN 46304		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	for its use; or in the consequences when should be reduced combinations of the Based on a compresident, the facility residents who have drugs are not give antipsychotic drug treat a specific condocumented in the residents who use receive gradual dephavioral interversidents who use receive gradual dephavioral interversidents who use receive gradual dephavioral interversidents drugs. Based on record the facility failed medication reging unnecessary medication reging unnecessary medication for high bloods are viewed for until The facility also PT/INR (a blood long it takes blooms it tak	or Resident #33 was 6/16 at 9:51 a.m. The oses included, but were lzheimer's, diabetes, and	F 03	329	F329 483.25(I) DRUG REGIMI IS FREE FROM UNNECESSADRUGS It is the practice of Chesterton Manor to ensure that each resident's drug regimen is free from unnecessary drugs. An unnecessary drug is defined any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate indications use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combination of these reasons I. Resident (# 16) related to adequate doses of sliding scale Insulin and anoth Resident (# 33) related to	as ut s of h	06/30/2016

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155246	B. W	ING		05/31/	2016
		<u> </u>		STREET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			VERLY DR		
CHESTE	RTON MANOR				ERTON, IN 46304		
					LIXION, IIN 70304		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					adequate doses of sliding sca		
	The Physician's	Order dated 11/21/14			Insulin and obtaining a PT/IN		
	indicated an ord	er for sliding scale			lab draw. Resident (#16) & (#		
		er blood glucose test			and completed per physician	Giai i	
		(insulin) subcutaneous			order. DON, or her designee	, will	
	(under the skin) before meals, with the				conduct an additional check t		
	following doses:				assure all labs are processed		
					appropriately. II. All residen		
	70-100=3 u				who have orders for sliding so		
	101-150=5 units				insulin and PT/INR lab draws		
	151-200=9 units				have the potential to be affect		
	201-250=13 units				by this alleged deficiency. All Resident lab orders reviewed		
	251-300=17 units				completed as ordered.	anu	
	301-350=21				Resident(#16) & (#33) lab ord	ders	
	201 200 21				clarified with physician and		
	Continued revie	w of the Physician's			completed per physician orde	er.	
		d a new order dated			DON, or her designee,will		
					conduct an additional check t	_	
		ng scale Novolog			assure all labs are processed		
		efore meals, with the			appropriately. III. As noted in survey findings, Chesterton	i the	
	following doses				Manor has a Diabetes Mellitu	9	
	<70=0 units	3			Policy and a Lab Ordering an		
	70-100=3 u	nits			Reporting Policy inplace.	-	
	101-150=5	units			Licensed nurses have been		
	151-200=10) units			re-educated on the		
	201-250=15				aforementioned policies on Ju		
	251-300=20				16, 2016. IV. All sliding scale		
					insulin orders and all PT/INR for all Residents have been	Iads	
	301-350=25				reviewed. In addition to the re	view	
	>351=Notif	y Physician			and re-education noted above	-	
					the DON, or her designee, is	-,	
	The 2/2016 Med	dication Administration			conducting a quality improver	ment	
	Record (MAR)	indicated, on 2/23/16 the			audit to ensure residents		
	resident's blood	glucose test result before			medication regimen is free fro		
		61, 5 units of insulin was			unnecessary medications rela		
		f insulin should have been			to adequate doses of sliding s	scale	
	-	mount should have been			Insulin and obtaining PT/INR	ato.	
I	administered.		1		results. A sample of 5 resider	แร	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155246	ľ í	JILDING	onstruction 00	(X3) DATE : COMPL 05/31 /	ETED
	PROVIDER OR SUPPLIER		•	110 BE	ADDRESS, CITY, STATE, ZIP CODE VERLY DR ERTON, IN 46304		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	The 3/20/16 MA the resident's blobefore lunch was was given, 13 umhave been adminresident's blood glunch was 191, 1 given, 9 units of administered. An resident's blood gdinner was 179, given, 9 units of administered. The 4/2016 MAI the resident's blobefore dinner was given, 5 unit been administered. The 5/2016 MAI the resident's blobefore breakfast was given, 3 unit been administered resident's blood gbreakfast was 16	R indicated, on 3/3/16 od glucose test result s 226, 17 units of insulin hits of insulin should histered. On 3/27/16 the glucose test result before 3 units of insulin was insulin should have been had on 3/27/16 the glucose test result before 5 units of insulin was insulin should have been R indicated, on 4/27/16 hod glucose test result has 103, 3 units of insulin has of insulin should have had. R indicated, on 5/8/16 hod glucose test result has 93, 5 units of insulin has of insulin should have had. On 5/26/16 the had glucose test result before had on 5/26/16 the had glucose test result before had on 5/26/16 the had glucose test result before had on 5/26/16 the had glucose test result before had on 5/26/16 the had glucose test result before had on 5/26/16 the			receiving sliding scale insuling be monitored for accuracy 3 times per week for 30 days, the monthly for 6 months. All residents receiving lab draws results will be monitored week for 30 days, then monthly for 6 months. Results of these auxill be reported monthly to the Quality Assurance meeting. A negative findings will add another four weeks of audits until 1000 compliance is achieved. V. Da Completion: June 30, 2016.	en and ly dits nny ther	
	the Director of N	2:58 a.m., interview with Jursing indicated the ministered the incorrect					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO JILDING	NSTRUCTION 00	COMPL		
		155246	B. W		<u></u>	05/31/	
	PROVIDER OR SUPPLIEF			110 BE\	DDRESS, CITY, STATE, ZIP CODE /ERLY DR ERTON, IN 46304	<u> </u>	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	ATE	(X5) COMPLETION DATE
mo	dose of insulin o 2. The clinical r was reviewed or The resident's di	n the above dates. ecord for Resident #16 a 5/25/16 at 2:35 p.m. agnoses included, but not tes mellitus, and a history		Mo			BAIL
	assessment dated resident was modern Brief Interview to score of 8. The anticoagulant modern	imum Data Set (MDS) d 4/15/16 indicated the derately impaired with a for Mental Status (BIMS) resident received an edication and insulin observation period.					
	indicated the res anticoagulant the The intervention limited to, daily	erapy related to disease. s included, but were not skin inspection and or labs as ordered, and					
	(POS) was revie 3/18/16 indicated	wed. An order Summary wed. An order dated d Warfarin Sodium addication - helps thin the ams (mg) daily.					
	indicated to cont	rder dated 4/23/16 inue the 4 mg of check the PT/INR again					

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO. UILDING	NSTRUCTION 00	COMPL	
		155246	B. W	ING		05/31/	2016
NAME OF F	PROVIDER OR SUPPLIEF		_		DDRESS, CITY, STATE, ZIP CODE VERLY DR		
CHESTE	RTON MANOR				ERTON, IN 46304		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
		1/29/16 indicated to e same dose and recheck /10/16.					
	Review of the lather following: -INR on 4/22/16 -INR on 4/29/16 -There was no recordered on 5/10/ Nursing Notes was 4/22/16 to 5/12/2 indicated "PT/IN Doctor) with no time. Lab order to do May 10. Order Appropriate part Interview with I 2:47 p.m., indicate received the lab was documentate further indicated	boratory results indicated =1.7 =1.9 esult for the PT/INR 16. vere reviewed from 16. On 4/29/16 the notes IR sent to MD (Medical Warfarin change at this received for PT/INR to er noted et faxed. ies notified." PN #2 on 5/26/16 at atted the resident had not draw, however, there ion sent to the lab. She the staff had not					
	the resident's Ph not been drawn to The Physician w 5/27/16 at 11:40	as notified by RN #2 on a.m. that the lab was e physician ordered a stat					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155246		l í	JILDING	nstruction 00	(X3) DATE COMPL 05/31	ETED	
	PROVIDER OR SUPPLIER		<u> </u>	110 BE\	DDRESS, CITY, STATE, ZIP CODE VERLY DR ERTON, IN 46304	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	3 NATE	(X5) COMPLETION DATE
	p.m., indicated the previously order results for the IN	s to maintain the same					
	Director of Nurs 10:26 a.m., titled Reporting Proced Management dat "POLICY: It is	ed 4/2013, indicated, the policy of this abs and report results in					
	indicated the res complications as mellitus. The int were not limited	deare plan dated 4/23/16 ident was at risk for sociated with diabetes erventions included, but to, glucose monitoring, dication as prescribed.					
	the resident was insulin by the was subcutaneously (based on a slidin	to receive Novolog by of a flexpen sq) four times a day g scale at 7:00 a.m., p.m., and 9:00 p.m.					
	The sliding scale 0-130=0 units 131-170=2 units	dose was as follows:					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155246	ľ	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 05/31 /	ETED
	PROVIDER OR SUPPLIER			110 BEV	DDRESS, CITY, STATE, ZIP CODE VERLY DR ERTON, IN 46304	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	171-210=3 units 211-250=5 units 251-290=6 units 291-330=7 units Above 330=8 un The May 2016 M Administration F the following: 5/15/16 at 9:00 p sugar was 310, d the resident recei The resident sho of insulin at that 5/24/16 at 9:00 p sugar was 328, d the resident recei The resident sho of insulin at that 5/26/16 at 6:00 a sugar was 139, d the resident recei The resident recei The resident sho of insulin at that Interview with the Clinical Services a.m., indicated the	its and call the Physician Medication Record (MAR), indicated o.m. the resident's blood ocumentation indicated ived 8 units of insulin. uld have received 7 units time. p.m. the resident's blood ocumentation indicated ived 8 units of insulin. uld have received 7 units time. m. the resident's blood ocumentation indicated ived 3 units of insulin. uld have received 2 units uld have received 2 units					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155246		A. BUILDING B. WING	<u>00</u>	COMPLETED 05/31/2016	
	ROVIDER OR SUPPLIER	110 BE	ADDRESS, CITY, STATE, ZIP CODE VERLY DR ERTON, IN 46304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	A current facility policy provided by the Director of Nursing (DON) on 5/31/16 at 10:30 a.m., titled, "Diabetes Mellitus - Routine Care", indicated, "Purpose: To provide nursing staff with guidelines for implementing care for the resident with diabetes mellitus. Objective: To provide care that will enable the resident to achieve and or maintain control of diabetes and to function safely in a natural environment" 3.1-48(a)(6) 3.1-49(a)				
F 0371 SS=D Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to ensure food was stored, prepared and served under sanitary conditions related to the use of gloves, dirty and greasy ovens, griddles, storage room, and cabinets for 1 of 1 kitchens. There was expired juice in the Unit Pantry for 1 of 1 pantries. (The	F 0371	DeficiencyID: F371 1. a. Diet cook was inserviced by the Dietary Manager, one-on-one 5/23/2016 on glove usage duri food prep. Cook was also give copy of the handwashing polic All Dietary staff will be in-service on the use of glove during food prep and hand washing on 6/21/16 Dietary Manager	on ng n a y. ced	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00 COM		COMPLETED	
		155246	B. W	ING		05/31/2016	
		_		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			VERLY DR		
CHESTE	RTON MANOR			CHEST	ERTON, IN 46304		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION)		TAG		DATE	
	Main Kitchen au	nd the Unit Pantry)			ordesignee will conduct rando observations of staff during me		
					prep to ensure compliance wit		
	Findings include	2 :			the above policies. See attach		
	1. On 5/23/16 at 8:50 a.m. the following				form. 2. a. Convection oven w		
					thoroughly cleaned and all dus	st	
	was observed du	aring the Brief Kitchen			and grease was removed on		
		with the Dietary Food			5/24/16. b. The corners and		
	Manager (DFM)				edges of the griddle were thoroughly cleaned on 6/9/16	<u> </u>	
		,-			The traditional oven was	0.	
	a Dietary Cool	r #1 was observed with			thoroughly cleaned on 5/23/16).	
	a. Dietary Cook #1 was observed with				d. Floor in the dry food storage	e	
	gloves to both of her hands. At that time, she was using a pair of scissors to cut				room was swept and wet mop	ped	
					on 5/23/16. e. All food		
		of raw spare ribs. She			transportation carts were thoroughly cleaned with a		
		ed touching the packages			pressure washer		
	of meat with her	r gloved hands. The			and disinfected. This included		
	Cook was obser	ved to remove the ribs			100 % of small and large servi	ice	
	from the packag	es with her gloved hands			carts, all Trash cans and		
	and placed them	in a pan for cooking.			associated dollies, four wheel		
	She was not obs	served to change her			plate carts, mixer stand, multi	blo	
		en using the scissors and			purpose drink carts and moval storage racks. This was	bie	
	touching the page				completed on 6/17/16. f. The	e	
	l to woming and pure	and a craw.			four white cabinets were clear		
	The current and	undated Handwashing			and sanitized on 6/9/16 and ha	ave	
		olicy provided by the			been repaired and repainted		
	_	of the provided by the on 5/31/16 at 11:00			Dietary Manager or designee		
					conduct a weekly sanitation at to ensure sanitary conditions i		
	_	gloves should be used			the kitchen. See attached form		
		food, if tongs or utensils			The expired products were		
		ob. Gloves should only			disposed of on 5/31/16. The		
		d then discarded.			Dietary staff will monitor the		
	Important to ren	nember that gloves can			contents of each refrigerator to		
	give a false sens	se of security and can			ensure that there are no expire products, three time per week		
	carry germs as h	nands.			See attached form. Dietary	•	
					Manager or designee will cond	duct	
	2. On 5/26/16 a	t 9:10 a.m., the following			a weekly sanitation audit 3x pe		

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NAME OF PROVIDER OR SUPPLIER CHESTERTON MANOR (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Was observed during the Full Kitchen Sanitation tour with the DFM: a. All the sides of the convection oven were dirty and greasy. The inside of the oven doors were dirty and brown stained. The knobs on the outside of the oven were sticky and dirty to touch. There was dust around and in the corners of the front panel. b. There was a large amount of thick black sludge and grease noted around the corner edges on top of the griddle. c. The inside of the traditional ovens were dirty with food spillage. d. The floor in the dry food storage room was dirty. There were sugar packets, fortune cookies, food crumbs, and a		NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155246	(X2) MUI A. BUI B. WIN	LDING	NSTRUCTION 00	(X3) DATE : COMPL 05/31 /	ETED
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Was observed during the Full Kitchen Sanitation tour with the DFM: a. All the sides of the convection oven were dirty and greasy. The inside of the oven doors were dirty and brown stained. The knobs on the outside of the oven were sticky and dirty to touch. There was dust around and in the corners of the front panel. b. There was a large amount of thick black sludge and grease noted around the corner edges on top of the griddle. c. The inside of the traditional ovens were dirty with food spillage. d. The floor in the dry food storage room was dirty. There were sugar packets,					110 BE\	/ERLY DR	•	
Sanitation tour with the DFM: a. All the sides of the convection oven were dirty and greasy. The inside of the oven doors were dirty and brown stained. The knobs on the outside of the oven were sticky and dirty to touch. There was dust around and in the corners of the front panel. b. There was a large amount of thick black sludge and grease noted around the corner edges on top of the griddle. c. The inside of the traditional ovens were dirty with food spillage. d. The floor in the dry food storage room was dirty. There were sugar packets,	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION
package of vanilla wafers observed on the floor. e. There were 3 transportation carts that were sticky to touch. The carts were used to transport food. f. There were 4 white cabinets above the counter, which stored dishes, that were dirty and sticky to touch. Interview with the DFM, at that time, indicated all the above was in need of	IAU	was observed du Sanitation tour vanitation vanit	ring the Full Kitchen with the DFM: of the convection oven reasy. The inside of the dirty and brown stained. The equation of the oven dirty to touch. There was in the corners of the arge amount of thick arge amount of thick argease noted around the top of the griddle. The traditional ovens food spillage. The dry food storage room were sugar packets, food crumbs, and a la wafers observed on transportation carts that such. The carts were used law the tored dishes, that were to touch. The DFM, at that time,		IAU	week for 90 days, then one per week for 90 days, should the deficient practice be identified audits will resume 3x weekly tweeks until deficiency is corrected. Results of these reviews will be presented mor at QA meeting, times 90 days after 90 days or review, no treor patterns are identified (three deficient practices per month considered a trend) then result will be reviewed quarterly.	nthly If the sends e is	DATE

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	ULTIPLE CO. UILDING	NSTRUCTION 00	COMPL		
THIND I LIMIT	or conduction	155246	B. W		00	05/31/	
		1002.10		CTD FFT A	DDDEGG CITY CTATE ZID CODE	00/01/	2010
NAME OF F	PROVIDER OR SUPPLIEF	R			DDRESS, CITY, STATE, ZIP CODE VERLY DR		
CHESTE	RTON MANOR				ERTON, IN 46304		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	cleaning.						
	C						
	3. On 5/31/16 a	t 8:55 a.m., the pantry on					
	the Main Nursin	g unit was observed.					
	Inside the refrigerator there were 2						
	unopened GNC Total Lean Shakes with a						
	_	of 8/26/15. There was 1					
	opened containe	r of Thirster Thickened					
	•	th a "Best Buy" date of					
March 25, 2016.							
1141611 25, 2016.							
	The current and	undated Refrigerated					
	Leftover Storage	e policy provided by the					
	DFM on 5/31/16	at 10:45 a.m., indicated					
	the product will	be disposed of on or					
	before the produ	ct expiration date.					
	Interview with the	he DFM on 5/31/16 at					
	9:09 a.m., indica	ated the items were					
	expired and show	ald have been thrown					
	away.						
	3.1-21(i)(3)						
F 0431	483.60(b), (d), (e)						
SS=D Bldg. 00	& BIOLOGICALS	S, LABEL/STORE DRUGS					
Diag. 00		employ or obtain the					
	services of a licen	sed pharmacist who					
		em of records of receipt					
		all controlled drugs in enable an accurate					
	Samoioni dotail to	Sind dir doddiato					

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155246	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/31/2016
	PROVIDER OR SUPPLIER ERTON MANOR	110 BE	ADDRESS, CITY, STATE, ZIP CODE EVERLY DR FERTON, IN 46304	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review and interview, the facility failed to ensure medications were labeled and stored properly related to dating medications when opened, labeling over the counter medications, and not using inhalers past the expiration date for 2 of 4 Medication carts in the facility. (Unit 1 and Unit 3) Findings include:	F 0431	F431 483.60 (e) Storage of Drugs and Biologicals It is to practice of Chesterton Manor to ensure medications are labeled and stored properly related to dating medications when opened, labeling over to counter medications, and not using inhalers past the expiration date. 1. Medication Cart on Unit 1 and Medication Cart on Unit 3 presented as outlined in the	he :

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Event ID:

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Facility ID: 000150

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED B. WING 05/31/2016		
155246 R WING 05/24/2016		
100240 25. 112.0	05/31/2016	
STREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER 110 BEVERLY DR		
CHESTERTON MANOR CHESTERTON, IN 46304		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)	
CROSS-REFERENCED TO THE APPROPRIATE	PLETION	
THE REGULATORY OR ESC IDENTIFY THIS INCOMPATION.	ATE	
1. Observation of the Medication Cart on Linit 3 on 5/24/16 at 2:28 n m. indicated Medication Cart on Unit 1 and		
Unit 3 on 5/24/16 at 2:28 p.m., indicated Medication Cart on Unit 1 and Medication Cart on Unit 3 on		
the following: were labeled appropriately with		
no expirationdates. All		
a. An Atrovent inhaler (an inhaler used Medication Carts on Units 1,2, 3		
to treat asthma) was dated as being & 4 were labeled appropriately		
opened 12/12/15 with no expiration dates.		
2.Aii residents who have		
b. A bottle of over the counter Aspirin prescribed medications have the potential to be affected by this		
The state of the s		
was not labeled with a resident's name		
and/or the Physician's name.		
Miscellaneous Product Expiration		
c. A Combivent inhaler (an inhaler used Date Policy and a Medication		
to treat respiratory issues) was dated as Labeling Policy in place.		
being opened 2/1/16 Licensed nurses have been		
1e-educated on the alore		
Interview with LPN #3 at the time, mentioned policies on June 16, 2016.		
interview with Elivino at the time,		
heen reviewed. In addition to the		
have been labeled with the resident's review and re-education noted		
name as well as the Physician's name. above the DON, or her designee,		
She also indicated the inhalers were is conducting a quality		
usually good for 90-days after being improvement audit to ensure		
opened. medications are labeled and stored properly related to the		
dating of medications when		
2. Observation of the Medication Cart on opened, labeling over the counter		
Unit 1 on 5/24/16 at 2:45 p.m., indicated medications, and inhalers are not		
a Combivent inhaler was not dated when present past the expiration date.		
All Medication carts will be		
opened. audited for medications dated		
when opened, labeling of over the counter medication appropriate		
and inhalars are not presentaget		
indicated the innaier should have been expiration dates 3 times per week		
dated when opened. dated when opened. for 30 days, then monthly for 6		
months. Results of these audits		
The Medication labeling policy was will be reported monthly to the		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155246		A. BUILDING B. WING	00	COM	PLETED	
		100240	_	ADDRESS, CITY, STATE, ZI		11/2010
	ROVIDER OR SUPPLIER		110 BE	EVERLY DR	. 0000	
CHESTE	RTON MANOR		CHES1	TERTON, IN 46304		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	policy was provi	1/16 at 11:11 a.m. The ded by the Nurse dentified as current. The the following:		Quality Assurance m negative findings wil four weeks of audits compliance is achiev 5.Date of Complet 2016.	ll add another until 100% ved.	
	by the Pharmacy manufacturer's o identified with the Facility personner resident's name of	riginal container and ne resident's name.				
	Date policy was 11:20 a.m. The the Nurse Consucurrent. The pole expired three more	ous Product Expiration reviewed on 5/31/16 at policy was provided by ltant and identified as icy indicated Combivent onths after first actuation. ultant also indicated this Atrovent.				
	3.1-23(0)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE COMPL		
ANDILAN	OF CORRECTION	155246	B. W		00	05/31/	
		133240	D			03/31/	2010
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CHESTE	RTON MANOR				EVERLY DR FERTON, IN 46304		
					1		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
F 0465	483.70(h)	ESC IDENTIFY THE IN ORWINTION		1710	· •		DATE
SS=E		AL/SANITARY/COMFOR					
Bldg. 00	TABLE ENVIRON						
· ·		rovide a safe, functional,					
	sanitary, and com- residents, staff and	fortable environment for d the public.					
	Based on observ	ation and interview, the	F 04	165	F 465	D) //	06/30/2016
	facility failed to	maintain a functional			SAFE/FUNCTIONAL/SANITA COMFORTABLE ENVIRON T		
	and sanitary envi	ironment related to			facility must provide a safe,	iie	
	marred walls and	doors, marred closet			functional, sanitary, and		
	doors and furnitu	re as well as stained			comfortable environment for		
	floor tile for 4 of	4 units throughout the			residents, staff and the public.		
	facility. The fac	ility also failed to			Marred walls, marred doors, u odors, stained floor tile and	ririe	
	maintain a functi	ional and sanitary			cracked base boards on 4 of 4	Į.	
	environment in t	he main kitchen related			halls throughout the facility. In		
	to dirty and rusty	ceiling vents, dirty			general areas of deficiency we		
	pipes, ice build u	ip in the freezer, an			identified as beginning presenthe following resident halls: Ha		
	accumulation of	dust and debris behind			100, 200, 300 and 400. Resident		
	the appliances, a	nd an accumulation of			rooms were identified as spec		
	dust and debris of	on the wheels of the			to, 1.) The 100 hall. a. The b		
	transportation ca	rts in 1 of 1 kitchen			non-skid strips on the floornex Bed "B" in Room 103 were	tt to	
	areas. (Units 1, 2	2, 3, and 4 and the Main			peeling. The inside of the		
	Kitchen)				bathroomdoor was also scrate	hed	
	,				and marred. One resident resi		
	Findings include	:			in this room.*Maintenance has		
					replaced Black peeling non-sk strips nest to bed "B", the	ilu	
	1. During the Er	nvironmental Tour on			bathroom door has been		
	5/31/16 at 9:25 a				repainted. b. The base of the		
	Maintenance and				closet door in Room 104 was		
		following was observed:			scratched and marred. One resident resided in this room.		
	,,	5			*Maintenance has repainted d	oor.	
	Unit 1				c. In Room 105, the bathroom		
					floor tile was stained undernea		
	a The black nor	n-skid strips on the floor			the sink. The bathroom door w		
		in Room 103 were			marred on the outside. The batter of the closet doors were also	15 C	
	nont to bed b	111 100111 103 WOIC			I said diddet doord word didd		

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Event ID:

SB6I11

Facility ID: 000150

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		155246	B. W	ING		05/31/2016	
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			VERLY DR		
CHESTE	RTON MANOR				ERTON, IN 46304		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	
		side of the bathroom door			marred. Two residents resided		
	was also scratch	ed and marred. One			this room. *House Keeping ha cleaned stained tile. d. The	S	
	resident resided	in this room.			dresser in Room 107 was		
					scratched and marred. One		
	b. The base of the	he closet door in Room			resident resided in this room.		
		ed and marred. One			*Maintenance has re-stained		
	resident resided				scratches and sealed area. e.		
	resident resided	iii tiiis 100iii.			The right side of the closet doo	or	
	. In Deam 105	41 1 41			was dented and marred at the base in Room 108. One reside	not .	
		, the bathroom floor tile			resided in this room. *Dent wa		
		erneath the sink. The			repaired and repainted by	"	
		vas marred on the			maintenance. f. The dresser in	1	
	outside. The bas	se of the closet doors			Room 112 was scratched and		
	were also marre	d. Two residents resided			marred. *Maintenance has		
	in this room.				re-stained scratches and seale		
					area. A section of the wall nex		
	d The dresser i	n Room 107 was			the dresser and thewall by the conditioning unit had chipped	all	
		arred. One resident			paint. * Wall area where chips		
	resided in this ro				were present has been repain	ted	
	resided in this re	om.			by maintenance. The bathroo	m	
	. Trl	C41 1			door and door frame had chipp		
	_	e of the closet door was			paint. Door area and frame wh	ere	
		ed at the base in Room			chips were present has been		
	108. One reside	nt resided in this room.			repainted by maintenance. The bathroom walls were marred a	i i	
					the paint was chipped.		
	f. The dresser in	n Room 112 was			*Maintenance has re-painted		
	scratched and m	arred. A section of the			walls. The base of the closet d	oor	
	wall next to the	dresser and the wall by			was scratched and marred. * 7		
		ing unit had chipped			closet door has been re-painte	ed.	
		oom door and door			One resident resided in this		
	_	ed paint. The bathroom			room. 2.) The 200 hall. a.) The base of the closet door in Roo		
		_			202 was marred. * The closet		
		ed and the paint was			door has been re-painted. Tw	o	
		ase of the closet door was			residents resided in this room.		
		arred. One resident			The base of the closet door wa	-	
	resided in this ro	oom.			scratched and marred in Roon		
					212. * The closet door has bee	en	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155246	B. W	ING		05/31/	2016
				CTDEET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
CHECTE	DTON MANOD				VERLY DR		
CHESTE	RTON MANOR			CHEST	ERTON, IN 46304		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	2. Unit 2				re-painted. The edge of the w	all	
					located next to the closet door	S	
	a The base of th	he closet door in Room			was marred and had chipped		
					paint. * Wall area where marrin		
		Two residents resided			was present has been repainte		
	in this room.				by maintenance. Two resident		
					resided in this room. 3.) The 3 hall. a.) In Room 305, the base		
	b. The base of the	he closet door was			the bathroom door was marred		
	scratched and m	arred in Room 212. The			and had chipped paint. * Wall	4	
		located next to the closet			area where chips were presen	t	
	_				has been repainted by	`	
		ed and had chipped paint.			maintenance. The floor tile in t	he	
	Two residents re	esided in this room.			bathroom was discolored infro	nt	
					of the sink and behind the toile	et. *	
	3. Unit 3				Housekeeping has removed		
					stains from floor. The bolts at t	-	
	a. In Room 305	the base of the			base of the toilet were expose		
		vas marred and had			*Bolt Caps have been replaced	d	
					with a new set. Two residents	_	
		The floor tile in the			reside in this room. b.) In Roor		
		iscolored in front of the			309, the closet door was scuffe and marred. * The closet door	c u	
	sink and behind	the toilet. The bolts at			has been re-painted. The edg	e of	
	the base of the to	oilet were exposed. Two			the wall next to the closet door		
	residents resided	•			had chipped paint. * The wall		
					area with chipped paint has be	en	
	h In Daam 200	41			re-painted. The door to the ro	om	
		, the closet door was			as well as the bathroom door v	was	
		red. The edge of the wall			marred and had chipped paint		
	next to the close	t door had chipped paint.			The doors to the room and the		
	The door to the	room as well as the			bathroom has been re-painted		
	bathroom door v	vas marred and had			Two residents resided in this		
		Two residents resided in			room. c.) The bedside stand in		
	this room.	o residente resided in			Room 312 next to Bed "A" was scratched and marred. *The	•	
	ulis iodili.				bedside stand scratches have		
					been painted. The bathroom d	oor	
		stand in Room 312 next			were scratched and marred. *		
	to Bed "A" was	scratched and marred.			The scratched on the door to t	he	
	The bathroom do	oor were scratched and			bathroom has been re-painted		
		Its at the base of the toilet			The bolts at the base of the to		
	I marroa. The bol	is at the base of the tollet	1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPL	ETED
		155246	B. WING 05/31/201			2016	
				CTD FET A	ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
					VERLY DR		
CHESTE	RTON MANOR			CHEST	ERTON, IN 46304		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	were exposed T	wo residents resided in			were exposed. *Bolt Caps hav	е	
	this room.	.,,			been replaced with a new set.		
	uns room.				Two residents reside in this		
					room.4.) The 400 hall a.) The		
	4. Unit 4				bedside stand in Room 404		
					across from Bed "A" was		
	a. The bedside s	stand in Room 404 across			scratched and marred at the		
	from Bed "A" w	as scratched and marred			base. *The bedside stand	The	
		base of the closet doors			scratches have been painted. base of the closet doors were	ıne	
					scratched and marred.* The		
		and marred. The upper			closet door has been re-painte	h	
		room door had chipped			The upper edge of the bathro		
	paint. The bolts	at the base of the toilet			door had chipped paint. * The	0111	
	were exposed.	Two residents resided in			scratches on the upper edge of	of	
	this room.				the door to the bathroom has		
					been re-painted. The bolts at	the	
	h In Doom 407	the dear frame and the			base of the toilet were expose	d. *	
		, the door frame and the			Bolt Caps have been replaced		
		rame were marred and			with a new set. Two residents		
	had chipped pair	nt. The inside of the door			reside in this room. b.) In Roo	om	
	was also marred	and had chipped paint.			407, the door frame and the		
	Two residents re	esided in this room.			bathroom door frame were marred and had chipped paint	*	
					The scratches to the door toth		
	c In Room 409	, the bathroom door			bathroom and frame have bee		
					re-painted. The inside of the d		
		ed and chipped. The			was also marred and had chip		
		also marred. One			paint. * This area has been	•	
	resident resided	in this room.			repainted. Two residents resid	е	
					inthis room. c.) In Room 409, t	he	
	d. The bathroon	n door in Room 411 did			bathroom door frame was mar		
		y. The door would not			and chipped. The closet door		
		ed. Two residents resided			also marred. * The scratches t	0	
		d. I wo residents resided			the closet door have been	lad	
	in this room.				re-painted. One resident resident		
					in this room. d.) The bathroom door in Room 411 did not shut		
	e. In Room 413	, the inside of the			correctly. The door would not	•	
	bathroom door v	vas marred and had			latch when closed. *The door l	has	
	chipped paint B	oth closet doors had			been rehung and the frame		
		ss. The baseboard by the			realigned to correctly shut the		
	I DIACK SCUIT HIALK	as. The vaseovalu by the	1		1		

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155246	B. W	ING		05/31/	2016
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R					
CHECTE					VERLY DR		
CHESTE	RTON MANOR			CHEST	ERTON, IN 46304		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	bathroom door	was peeling away from			latch has been repaired. Two		
		wall was gouged by the			residents reside in this room.		
		along the corner edge.			In Room 413, the inside of the		
		_			bathroom door was marred an		
	I wo residents r	esided in this room.			had chipped paint. * This area		
					has been repainted. Both close		
	Interview with t	he Maintenance			doors had black scuff marks. T scuffs have been repainted. The		
	Supervisor at th	e time, indicated all of			baseboard by the bathroom do		
	_	were in need of repair.			was peeling away from the wa		
		at 8:50 a.m. the following			and the wall was gouged by th		
					bathroom door along the corne		
		uring the Brief Kitchen			edge. *The gouged area has		
	Sanitation tour with the Dietary Food				been repaired and repainted.	Гһе	
	Manager (DFM):				baseboard has been re-glued	to	
					the wall. Two residents resided	d in	
	a. The ve	ent above the dish machine			this room. Interview with the		
	had a la	arge accumulation of dirty			Maintenance Supervisor during	g	
		st. The vent was also			survey indicated all the above		
		st. The vent was also			was in need of cleaning and/or	ſ	
	rusty.				repair. Housekeeping has completed the necessary deep		
					cleaning of rooms affected for	,	
	b. The wh	ite PVC pipes under the			correction of any additional		
	garbage	e disposal and under the			stains. Maintenance will record	dina	
	three co	ompartment sink were dirty			purposes for rooms identified I		
		od and/or beverage			upcoming audits via the TELS	-	
		· ·			work order or system. Weekly		
	spillage	.			room audits via TELS system	has	
					set this as a weekly task for		
	c. There v	vas a large amount of ice			scuffs scrapes and side rails.		
	build-u	p on the ceiling and the			audit tool will be kept of weekly		
	floor in	the walk in freezer. There			room audits. 3 times per week	tor	
	were ch	nunks of ice adhered to the			30 days,then monthly for 6 months. Results of these audit		
		nd the ceiling was dripping			will be reported monthly tothe	.o	
					Quality Assurance meeting. A	nv	
	with wa	ner.			negative findings will add anot		
					four weeks of audits until 100%		
	d. The har	nd washing sink by the			complianceis achieved. A reco		
	convec	tion oven was stained and			of maintenance for room repai		
	discolo	red.			will be kept for this period of al		
	1		1		I		

STATEMEN	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORREC	CTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00 COMPLETED			
			155246	B. W	ING		05/31/2016	
					STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER (OR SUPPLIEF	8			VERLY DR		
CHESTE	RTON M.	ANOR				ERTON, IN 46304		
(X4) ID			TATEMENT OF DEFICIENCIES		ID	(X5)		
PREFIX			CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGU	LATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	
						work completed in the plan of		
	e.	There w	as a large amount of dust			correction book, as well as in t		
		and dirt	behind the stove,			TELS work ordersystem and a corresponding record of the wo		
			ion ovens, the griddle, and			will be placed in the system as		
			o fryer. The gas pipes			awork order for recording		
		-				purposes. This record will be		
			the stove were greasy and			completed by maintenance, th	e	
		dusty.				administrator, or a designee. [
						of Completion for identified		
	f.	The who	eels on the mixer were			deficiencies: June 30, 2016.5.		
		dirty an	d greasy.			5/23/16 at 8:50 a.m. the follow		
		J	C 3			was observed during the Brief		
	6 On	5/26/16 a	t 9:10 a.m., the following			Kitchen Sanitation tour with the	~	
			•			Dietary Food Manager(DFM): The vent above the dish mach		
			ring the Full Kitchen			had alarge accumulation of dir		
	Sanıtat	ion tour v	vith the DFM:			and dust. The vent was also	·y	
						rusty. *The Vent has been		
	a.	The 3 t	ransportation carts were			cleaned and repainted and		
		sticking	to touch and the wheels			reinstalled. 5/23/2016 b. The		
		were di	ty and greasy.			white PVC pipes under the		
						garbage disposal and under th	ne	
	b.	The enc	losed transportation cart			three compartment sink were		
	0.		_			dirty with food and/or beverage		
		wneels	were dirty and greasy.			spillage. * The PVC pipes und the garbage disposal were	CI	
						cleaned, surfaces in surroundi	na	
	Intervi	ew with the	he DFM, at that time,			area was cleaned anddisinfect	•	
	indicat	ed all the	above was in need of			completed 5/23/16. c. Therewa		
	cleanin	g and/or	repair.			a large amount of ice build-up		
			-			the ceiling and the floor in the		
	3.1-19((f)				walk infreezer. There were		
	J.1 17((*)				chunks of ice adhered to the fl		
						and the ceiling was dripping w	itn	
						water. *The vendor was	n	
						contacted to inspect the walk i freezer;they repaired and	11	
						re-sealed penetration to walls	and	
						ceilings in affected areas	and .	
						replacement Dietary staff are		
						monitoring, cleaning and		
				ı		I		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155246	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/31/2016
	ROVIDER OR SUPPLIER	2	110 BE	ADDRESS, CITY, STATE, ZIP CODE EVERLY DR FERTON, IN 46304	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N (X5) SE COMPLETION DATE
				defrosting two times/week. Completed repairs. 6/6/2010 area will be monitored week cleaned to prevent the pote for ice build-up. d. The hand washing sink by the convection oven was stained and discoute A thoroughcleaning of the and surrounding area has be completed. 5/23/2016 e. Therewas a large amount of and dirt behind the stove, convection ovens, the gridd the deep fryer. The gas pipe behind the stove were great and dusty. * The entire area behind the stove, grill and gripping was degreased and cleaned. Completed 5/23/20 The wheelson the mixer were dirty and greasy. * Wheels of mixer werethoroughly cleaned 6/9/16.6. On 5/26/16 at 9:10 the following was observed the Full Kitchen Sanitation the with the DFM: a. The 3 transportation carts were stituted to touch and the wheels were dirty and greasy. *Wheels of transportation carts were powashed and cleaned. Completed 6/17/2016b. The enclosed transportation cart wheels were dirty and greasy. *Wheels of enclosed transportation cart wheels were dirty and greasy. *Wheels of enclosed transportation cart wheels were dirty and greasy. *Wheels of enclosed transportation cart wheels were dirty and greasy. *Wheels of enclosed transportation cart wheels were dirty and greasy. *Wheels of enclosed transportation cart wheels were dirty and greasy. *Wheels of enclosed transportation cart wheels were dirty and greasy. *Wheels of enclosed transportation cart wheels were dirty and greasy. *Wheels of enclosed transportation cart wheels were dirty and greasy. *Wheels of enclosed transportation cart wheels were dirty and greasy. *Wheels of enclosed transportation cart wheels were dirty and greasy. *Wheels of enclosed transportation cart wheels were dirty and greasy. *Wheels of enclosed transportation cart wheels we dirty and greasy. *Wheels of enclosed transportation cart wheels we dirty and greasy. *Wheels of enclosed transportation cart wheels we dirty and greasy. *Wheels of enclosed transportation cart wheels we dirty and greasy. *Wheels of enclosed transportation cart wheels we	dy and intial distriction dored. sink een f dust des siy as eep on the connection our decking ree in the cower oleted decree in the cower on the cow

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING 00			ETED
		155246	B. WIN	NG	05/31/	2016	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR				
CHESTERTON MANOR				CHEST	ERTON, IN 46304		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					audits will resume 3x weekly for weeks until deficiency is corrected. Results of these reviews will be presented mon at QA meeting, times 90 days, after 90 days or review, no tree or patterns are identified (three deficient practices per month is considered a trend) then result will be reviewed quarterly.	thly If nds e	

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If continuation sheet

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